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# Comparison of clinical characteristics in good and poor insight obsessive–compulsive disorder

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**Abstract**

Beginning with DSM-III-R, the condition of an intact insight towards obsessive–compulsive symptoms, which was essential for the classical definition of obsessive–compulsive neurosis, has been removed, permitting inclusion of cases with poor insight. A total of 94 cases who met DSM-III-R criteria for obsessive–compulsive disorder were included in this study. The Structured Clinical Interview for DSM-III-R (SCID-P), Yale–Brown Obsessive Compulsive Scale (Y-BOCS), Hamilton Rating Scale for Depression (HRSD), Hamilton Rating Scale for Anxiety (HRSA), and State–Trait Anxiety Inventory (STAI) were administered to each patient. Two subgroups determined by DSM-IV item ''poor insight'' were compared for demographic variables and the scores obtained on the scales. Scores on the Y-BOCS, HRSA, HRSD and STAI-state were significantly higher in the poor insight group. Current and past major depression were also more frequent. Among personality disorders (PDs), avoidant PD was more common in the good insight group and borderline and narcissistic PDs were more common in the poor insight group. HRSA, HRSD, and STAI-state scores had weak to moderate but significant correlations with insight as defined by the item 11 of Y-BOCS. Findings are discussed in view of previous reports.


*Keywords:* Obsessive–compulsive disorder; Insight; Clinical features; Obsession; Compulsion

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## 1. Introduction

The problem of insight has been a key issue in the series of debates surrounding the definition of obsessive–compulsive disorder (OCD). First of all, obsessions and compulsions also occur in psychoses, and this calls for a clear-cut boundary between neurotic and psychotic obsessions and compulsions. The traditional gold standard in making the distinction has been presence of insight in the former (Reed, 1985; Snaith, 1981).

Secondly, as many authors addressing OCD have noted, presence and degree of insight may change considerably from one patient to another and over the course of the disorder (Freud, 1966; Insel & Akiskal, 1986; Kozak & Foa, 1993; Lelliott, Noshirvani, Basoglu, Marks, & Monteiro, 1988; Robinson, Winnik, & Weiss, 1976; Solyom, DiNicola, Phil, Sookman, & Luchins, 1985), making such a distinction difficult at times, if not altogether impossible.

And thirdly, it has been noted that patients with poor insight also respond to treatment poorly (Basoglu, Lax, Kasvikis, & Marks, 1988; Eisen & Rasmussen, 1993; Foa, 1979; Insel & Akiskal, 1986; Jenike, Baer, Minichiello, Schwartz, & Carey, 1986; Solyom et al., 1985), raising the question of whether there is a subgroup of ''atypical'' OCD patients whose symptoms are more severe. In case such a group exists, would it not be more appropriate to classify these patients under a separate entity or under psychoses? Hoch and Polatin described a case with ''pseudoneurotic schizophrenia'' in as early as 1949 (cited in Spitzer, Skodol, Gibbon, & Williams, 1981). Strauss (1948), Weiss, Robinson, and Winnik (1969) and also Solyom et al. (1985) offered ''obsessive psychosis,'' Insel and Akiskal (1986) offered ''OCD with psychotic features,'' and Rasmussen and Tsuang (1986) offered ''chronic deteriorative OCD.'' However, subpopulations defined by those terms are not necessarily identical.

Appropriateness of classifying some ''atypical'' cases with poor insight under the classical entity of OCD has been questioned by many authors in recent years. The first one to note that obsessive patients do not necessarily have insight into the senselessness of their beliefs was Lewis (1936) who, as Jakes (1996) pointed out, also employed the term ''resistance'' in a special way to broaden the definition of OCD. However, with the attempts to use uniform criteria in classification getting stronger in DSM-III (American Psychiatric Association, 1980), the definition became somewhat stricter. Still, it may be interesting to note that in the historical cases section of the official casebook for DSM-III, Spitzer et al. (1981) re-diagnosed a case with probably negative insight as OCD, arguing against the original diagnosis of ''pseudoneurotic schizophrenia'' offered by Hoch and Polatin. The tendency to broaden the definition gained ground in time and resulted in a loosening of the criterion ''insight into senselessness'' in DSM-III-R (American Psychiatric Association, 1987), which admitted that this '' ... may no longer be true for people whose obsessions have evolved into overvalued ideas.'' DSM-IV went even further by stating that obsessions or compulsions must be recognized as excessive or unreasonable not necessarily earlier, but ''at some